BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

In the Matter of the Application for an Award of Advocacy and Witness Fees of: The Western Center On Law And Poverty, Inc., a California corporation, Applicant.	**DMHC Decision 10-06-03 June 29, 2010** Application Received Date: March 18, 2010 Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 For 28 CCR § 1300.67.2.2 (Re: Timely Access)

DECISION GRANTING AWARD OF ADVOCACY AND WITNESS FEES TO THE WESTERN CENTER ON LAW AND POVERTY, INC., A CALIFORNIA CORPORATION, FOR SUBSTANTIAL CONTRIBUTION TO PROCEEDING CONTROL NOS. 2002-0018, 2005-0203 AND 2008-1579

1. SUMMARY

This decision awards The Western Center On Law And Poverty, Inc., a California corporation ("Western Center" or "APPLICANT"), Advocacy and Witness Fees for its substantial contribution to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 of the Department of Managed Health Care ("Department") regarding Timely Access ("proposed regulation"), which became final as set forth at 28 CCR §1300.67.2.2 ("regulation"). The award represents a decrease from the amount requested in order to not exceed Market Rate, for the reasons stated herein.

2. BACKGROUND OF CONSUMER PARTICIPATION PROGRAM

The Consumer Participation Program ("Program" or "CPP"), enacted in Health and Safety Code § 1348.9 ("Statute"), required the Director ("Director") of the Department to adopt regulations to establish the Program to allow for the award of reasonable advocacy and witness fees to any person or organization that (1) demonstrates that the person or organization represents the interests of consumers and (2) has made a substantial contribution on behalf of consumers to the adoption of any

regulation or to an order or decision made by the Director if the order or decision has the potential to impact a significant number of enrollees.

The Statute requires the regulations adopted by the Director to include specifications for: (1) eligibility of participation, (2) rates of compensation, and (3) procedures for seeking compensation. The Statute specifies that the regulations shall require that the person or organization demonstrates a record of advocacy on behalf of health care consumers in administrative or legislative proceedings in order to determine whether the person or organization represents the interests of consumers.

Pursuant to the Statute, the Program regulations were adopted as section 1010 of Title 28 of the California Code of Regulations (the "Regulations"). The Regulations specified:

a. Definitions for the Program, including: "Advocacy Fee," "Compensation," "Market Rate," "Represents the Interests of Consumers," "Substantial Contribution," and "Witness Fees." (§ 1010, subsection (b)).

b. Procedure for a Request for Finding of Eligibility to Participate and Seek Compensation (§ 1010, subsection (c)), which is required to be eligible to participate in the Program.

c. Procedure for Petition to Participate (§ 1010, subsection (d)), which is required to participate in each specific proceeding.

d. Procedure for Applying for an Award of Fees. (§ 1010, subsection (e)).

3. REQUIREMENTS FOR AWARDS OF ADVOCACY AND WITNESS FEES

3.1. PROCEDURAL REQUIREMENTS

All of the following procedures must be followed and criteria satisfied for a person or organization that represents the interests of consumers to obtain a compensation award:

a. To become a "Participant," the person or organization must satisfy the requirements of either or both of the following by:

(1) Submitting to the Director a Request for Finding of Eligibility to Participate and Seek Compensation in accordance with 28 CCR § 1010(c), at any time independent of the pendency of a proceeding in which the person seeks to participate, or by having such a finding in effect by having a prior finding of eligibility in effect for the two-year period specified in 28 CCR § 1010(c)(3).

(2) Submitting to the Director a Petition to Participate in accordance with 28 CCR § 1010(d), no later than the end of the public comment period or the date of the first public hearing in the proceeding in which the proposed Participant seeks to become involved, whichever is later (for orders or decisions, the request must be submitted within ten working days after the order or decision becomes final).

b. The Participant must submit an "application for an award of advocacy and witness fees" in accordance with 28 CCR § 1010(e), within 60 days after the issuance of a final regulation, order or decision in the proceeding.

c. The Participant must have made a Substantial Contribution to the proceeding. (Health & Saf. Code § 1348.9(a); 28 CCR § 1010(b)(8)).

d. The claimed fees and costs must be reasonable (Health & Saf. Code § 1348.9(a)) and not exceed market rates as defined in 28 CCR § 1010.

3.2. APPLICANT'S APPLICATION FOR FINDING OF ELIGIBILITY TO PARTICIPATE

On March 13, 2004, APPLICANT submitted its Request for Finding of Eligibility to Participate and Seek Compensation with the Department, giving notice that it represents the interests of consumers and of its intent to claim compensation.

On or about July 30, 2004, the Director ruled that APPLICANT was eligible to participate and to seek an award of compensation.

On October 12, 2006, APPLICANT submitted its Request for [Renewal] of Finding of Eligibility to Participate and Seek Compensation in the CPP, giving notice that it represents the interests of consumers and of its intent to claim compensation.

On or about October 19, 2006, APPLICANT's Request for [Renewal] of Finding of Eligibility to Participate and Seek Compensation was approved.

On February 10, 2010, APPLICANT submitted its Request for [Renewal] of Finding of Eligibility to Participate and Seek Compensation in the CPP, giving notice that it represents the interests of consumers and of its intent to claim compensation.

By email dated February 18, 2010, Notice of Ruling on Request for Renewal of Finding of Eligibility to Participate and Seek Compensation was given that the APPLICANT was eligible to participate in the CPP and to seek an award of compensation.

3.3. APPLICANT'S PETITION TO PARTICIPATE IN THE TIMELY ACCESS PROCEEDING

On September 28, 2004, APPLICANT submitted its Petition to Participate (Petition) in the Timely Access rulemaking proceeding. In its Petition, APPLICANT estimated its fees to be $5,000.00. In its Petition, APPLICANT stated the following with respect to Timely Access issues:

> "Western Center on Law and Poverty provided support and policy guidance to Health Access in the development of AB 2179 Cohn that requires these regulations. WCLP has also been solicited by the Director for input on the development of these pending regulations. In our Medi-Cal managed care advocacy work, we monitor complaints from local health advocacy organizations to identify access problems and

propose solutions. We also monitor network adequacy with regard to Medi-Cal managed care plans."

On October 28, 2004, the Director approved APPLICANT's Petition to Participate in the Timely Access rulemaking proceeding.

On June 24, 2009, APPLICANT submitted its Petition to Participate (Petition) in the Timely Access rulemaking proceeding. In its Petition, APPLICANT estimated its fees to be $25,000.00. In its Petition, APPLICANT stated the following with respect to Timely Access issues:

> "We work closely with local legal services and other organizations who directly serve clients needing to access health care services, including clients who have difficulties in accessing a provider in a timely manner. We have already been asked by the Department to participate in the informal drafting of the Timely Access to Care regulations and have spent considerable time working within our coalitions to determine the best course of action that both serves the needs of the consumers, particularly low-income consumers with additional barriers to access to care, and to satisfy the intent of the authorizing legislation."

By email dated June 25, 2009, APPLICANT's Petition to Participate was granted as re-approval of participation in the Timely Access rulemaking proceeding, and the Petition was treated as an amendment of APPLICANT's prior Petition in order to provide an amended estimate of fees to be sought (in accordance with 28 CCR § 1010(d)(5)).

3.4. APPLICATION FOR AWARD OF ADVOCACY AND WITNESS FEES

The regulation became final and effective on January 17, 2010. Within 60 days thereafter (on March 18, 2010), APPLICANT timely submitted its Application for an Award of Advocacy and Witness Fees (Application). 28 CCR § 1010(e)(1).

After the Application was publicly noticed, no objections to the Application were received.

The application for an award of compensation must include (as required by 28 CCR § 1010(e)(2) and (3)):

> "a. A detailed, itemized description of the advocacy and witness services for which the Participant seeks compensation;
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> b. Legible time and/or billing records, created contemporaneously when the work was performed, which show the date and the exact amount of time spent[1] on each specific task;[2] and

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[1] "...the phrase 'exact amount of time spent' refers either to quarters (15 minutes) of an hour for attorneys, or to thirty (30) minute increments for non-attorney advocates." 22 CCR § 1010(e)(3).

[2] "The phrase 'each specific task,' refers to activities including, but not limited to:

a. Telephone calls or meetings/conferences, identifying the parties participating in the telephone call, meeting or conference and the subject matter discussed;

b. Legal pleadings or research, or other research, identifying the pleading or research and the subject matter;

c. Letters, correspondence or memoranda, identifying the parties and the subject matter; and

c. A description of the ways in which the Participant's involvement made a Substantial Contribution to the proceeding as defined in subpart (b)(8), supported by specific citations to the record, Participant's testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence." 28 CCR § 1010 (e)(2).

With its Application, APPLICANT submitted a billing specifying the dates of services, a description of each specific task or each activity of advocacy and witness service, identification of the person providing each service, the elapsed time (exact amount of time spent) for each service in quarters (15 minutes) of an hour for attorney advocates and in 0.5 hour or 30 minute increments for non-attorney advocates, and the hourly rate requested.[3] The total fees requested for work performed by APPLICANT is $47,785.50.[4]

The Hearing Officer finds that the Application of APPLICANT substantially complies with the technical requirements of 28 CCR § 1010(e)(2) and (3).

4. PROCEDURAL HISTORY

The evolution of the Timely Access proceeding consisted of informal stakeholders meetings and three noticed proceedings with three proceeding control numbers identified as follows.

4.1. PROCEEDING CONTROL NO. 2002-0018 – Access to Needed Health Care Services, amending section 1300.67.2 and adopting sections 1300.67.2.2 and 1300.67.2.3 in title 28, California Code of Regulations

On July 9, 2004, the Department issued a Notice of Proposed Rulemaking proposing to amend 28 CCR section 1300.67.2, adopt 28 CCR sections 1300.67.2.2 and 1300.67.2.3, and establishing a 45-day comment period from July 9, 2004 to August 23, 2004.

Initially, no public hearing was scheduled on the proposed regulations.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2002-0018, the Department stated that:

> "California Health and Safety Code sections 1344 and 1346 vest the Director with the power to administer and enforce the provisions of the Act.
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> California Health and Safety Code section 1344 mandates that the Director have the ability to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of this chapter, including rules governing applications and reports, and defining any terms, whether or not used

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d. Attendance at hearings, specifying when the hearing occurred, subject matter of the hearing and the names of witnesses who appeared at the hearing , if any." 28 CCR § 1010(e)(3)a, b, c, and d.

[3] Under the PUC Intervenor Compensation Program, the intervenors submit time logs to support the hours claimed by their professionals. Those logs typically note the dates, the number of hours charged, and the issues and/or activities in which each was engaged. D.06-11-009 (November 9, 2006), p. 26.

[4] Although $47,785.00 is the amount requested at the beginning of the Application, within the Application the amounts per attorney totaled $47,785.50.

in this chapter, insofar as the definitions are not inconsistent with the provisions of the Act. Furthermore, the Director may waive any requirement of any rule or form in situations where in the Director's discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to this chapter. In addition, the Director may honor requests from interested parties for interpretive opinions.

California Health and Safety Code section 1346 vests in the Director the power to administer and enforce the Act, including but not limited to recommending and proposing the enactment of any legislation necessary to protect and promote the interests of plans, subscribers, enrollees, and the public.

Health and Safety Code section 1367.03 requires the Department to develop and adopt regulations to ensure that enrollees have timely access to needed health care services. The Director proposes amending section 1300.67.2 and adopting sections 1300.67.2.2 and 1300.67.2.3 in Title 28, California Code of Regulations to effectuate section 1367.03 by setting forth minimum standards with which health care service plans (plans) shall comply to ensure that enrollees have timely access to needed health care services.

The proposed regulations set access to care standards concerning the availability of primary care physicians, specialty care physicians, hospital care, and other specified health care services to ensure that enrollees have timely access to care.

Amending section 1300.67.2 and adopting sections 1300.67.2.2 and 1300.67.2.3 shall benefit enrollees because it will ensure that plans provide health care services within reasonable proximity of the business or residence of the enrollee including accessible emergency health care services. The regulation clarifies that all services offered by the plan be accessible without delays detrimental to the health of the enrollees and set timelines for routine non-urgent care, urgent care and preventive care. This will ensure that plan enrollees will receive needed health care services within a reasonable timeframe, while not be overburdening the plans or providers."

A Public Hearing on the proposed regulation was scheduled, noticed for, and held on August 16, 2004.

On August 17, 2004, the Department issued an Amended Notice of Proposed Rulemaking proposing to amend 28 CCR section 1300.67.2 and adopt 28 CCR sections 1300.67.2.2 and 1300.67.2.3, and extending the public comment period for 30 days to September 22, 2004.

The Department requested input regarding the proposed regulations at a stakeholder meeting held on September 13, 2004, in order to increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45. Notes regarding comments provided at the meeting were included in the record of the proceedings.

On September 15, 2004, the Department issued an Amended Notice of Proposed Rulemaking proposing to amend 28 CCR section 1300.67.2, adopt 28 CCR sections 1300.67.2.2 and 1300.67.2.3, and extending the public comment period for 45 days to November 8, 2004.

The Department requested input regarding the proposed regulations at a stakeholder meeting held on October 20, 2004, in order to increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45. Notes regarding comments provided at the meeting were included in the record of the proceedings.

On April 1, 2005, the Department issued a Notice of a Second Public Comment Period for 15 days ending April 22, 2005, regarding the proposed regulation modified as a result of comments received in the prior comment period.

By letter dated April 19, 2005, the Department gave notice of intention to withdraw the proposed regulations from the proceeding and to propose a revised version of the regulations pursuant to a new rulemaking proceeding. A formal Notice of Decision Not To Proceed was published on April 29, 2005.

4.2. PROCEEDING CONTROL NO. 2005-0203 -- Timely Access To Health Care Services, adopting section 1300.67.2.2 in title 28, California Code of Regulations

Beginning in October of 2006, the Department invited parties who would be the subject of the proposed regulation to public discussions ("stakeholder meetings") in order to increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45. Stakeholder meetings were held during October and November of 2006.

On January 12, 2007, the Department issued a Notice of Proposed Rulemaking and Notice of Public Hearing proposing to adopt 28 CCR section 1300.67.2.2, establishing a 52-day written comment period from January 12, 2007 through March 5, 2007, and scheduling a Public Hearing to be held on March 5, 2007. The scheduled Public Hearing was held on March 5, 2007.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2005-0203, the Department stated that:

> "The Department proposes to adopt section 1300.67.2.2 pursuant to California Health and Safety Code section 1367.03, which specifically authorizes the Department to develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. Section 1367.03 directs the Department to develop indicators of and standards for timeliness of access to care.
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> AB 2179 (2002) added section 1367.03 of the Health and Safety Code, expressly instructing the Department to develop and adopt regulations to assure timely access to health care. The statute also contained specific requirements

for the content of the regulations, including requirements that the regulations establish indicators of timeliness of access to care, adopt standards for timely access to health care services, and specify the manner in which health care service plans are to report annually to the Department on compliance with the standards. Accordingly, the regulation establishes standards and requirements related to: timely access to primary care physicians, specialty physicians, hospital care, and other health care; health plan monitoring of health care provider compliance with the standards; corrective action by health plans upon identifying deficiencies in compliance; and the statutory requirement of filing an annual report of compliance.

The statute requires the adoption of "time elapsed" standards specifying the time elapsed between the time an enrollee seeks health care and obtains care. The statute also authorizes the Department to adopt standards other than time elapsed but requires the Department to demonstrate why such standard other than time elapsed is "more appropriate." Proposed section 1300.67.2.2 adopts time elapsed standards and proposes a "same-day access" standard which is demonstrated to be "more appropriate" than time elapsed standards because timeliness of access under the same-day access standard exceeds timeliness of access under all of the time elapsed standards of the proposed regulation.

In Section 1 of AB 2179, the Legislature found and declared 'that timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of adequate provider panels, fiscal distress of a health care service plan or a health care provider, or shifts in the health needs of a covered population.'"

On July 16, 2007, the Department issued a Notice of a Second Public Comment Period for 45 days from July 16, 2007 through August 30, 2007, and Notice of Second Public Hearing for August 13, 2007. By notice dated August 8, 2007, the Department rescheduled the Second Public Hearing to September 18, 2007, and extended the Second Public Comment Period for 21 days ending September 21, 2007. The rescheduled Public Hearing was held on September 18, 2007.

On December 10, 2007, the Department issued a Notice of a Third Public Comment Period for 16 days from December 10, 2007 through December 26, 2007.

On January 11, 2008, the Department submitted the proposed regulation to the Office of Administrative Law ("OAL") for review in accordance with the Administrative Procedure Act ("APA"). On February 27, 2008, the OAL disapproved the proposed regulation. The OAL issued a Decision of Disapproval of Regulatory Action dated March 5, 2008.

4.3. PROCEEDING CONTROL NO. 2008-1579 – Timely Access to Non-Emergency Health Care Services, adopting section 1300.67.2.2 in title 28, California Code of Regulations

In June and September of 2008, the Department invited parties who would be the subject of the proposed regulation to public discussions ("stakeholder meetings") in order to further increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45.

On January 9, 2009, the Department issued a Notice of Proposed Rulemaking Action proposing to adopt 28 CCR section 1300.67.2.2 and establishing a 45-day comment period from January 9, 2009 to February 23, 2009.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2008-1579, the Department stated that:

> "The Department proposes to adopt section 1300.67.2.2 to establish standards and requirements for timely access as required by section 1367.03.
>
> AB 2179 (2002) added section 1367.03 of the Health and Safety Code, directing the Department to develop and adopt regulations to ensure that enrollees have timely access to needed health care services. In Section 1 of AB 2179 the Legislature found and declared 'that timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of adequate provider panels, fiscal distress of a health care service plan or a health care provider, or shifts in the health needs of a covered population.'
>
> Section 1367.03 contains a number of requirements regarding the development and content of the regulations, including specified factors to be considered by the Department in developing the regulations, requirements for contracts between plans and providers, and annual plan reporting requirements. The proposed regulations have been developed in accordance with the legislative directive set forth in Section 1367.03.
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> These proposed regulations adopt a balanced approach, to achieve workability and provide for operational flexibility, by establishing both performance standards and prescriptive time-elapsed standards; reasonable mechanisms to preserve the relevance of the clinical judgment of providers, provisions to encourage best practices for enhanced accessibility and a mechanism for enrollees to obtain assistance in determining the relative urgency of their need [for] an appointment. These proposed regulations also strike a reasonable balance with meaningful performance standards for quality assurance monitoring by plans and their delegated provider groups."

Initially, no public hearing was scheduled on the proposed regulations. However, by letter dated January 28, 2009, a representative of the California Medical Association requested that a public hearing be held.

On January 30, 2009, the Department issued an Amended Notice of Rulemaking Action and Public Hearing Agenda. The Public Hearing was scheduled for, and held on, February 23, 2009.

On June 10, 2009, the Department issued a Notice of Second Comment Period and modified Proposed Text for 15 days from June 10, 2009 through June 25, 2009.

On July 23, 2009, the Department issued a Notice of Third Comment Period and modified Proposed Text for 15 days from July 23, 2009 through August 7, 2009.

On September 28, 2009, the Department issued a Notice of Fourth Comment Period and modified Proposed Text for 15 days from September 28, 2009 through October 13, 2009.

On or about November 3, 2009, the Department issued an Updated Informative Digest for Timely Access to Non-Emergency Health Care Services (2008-1579) as follows:

> "As required by section 11346.9 of the Government Code, the Director of the Department of Managed Health Care (Director) sets forth below the updates to the Informative Digest for this rulemaking action proposing the addition of section 1300.67.2.2 to title 28, California Code of Regulations (Regulations).
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> **Authority and Reference**
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> Pursuant to Health and Safety Code section 1341.9, the Department of Managed Health Care (Department) is vested with all duties, powers, purposes, responsibilities, and jurisdiction as they pertain to health care service plans (plans) and the health care service plan business.
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> Health and Safety Code section 1344 grants the Director authority to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act).
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> Health and Safety Code section 1367.03, added to the Knox-Keene Act pursuant to AB 2179, (stats. 2002, c. 797) requires the Department to develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner by developing indicators of timeliness of access to care and developing standards for timeliness of access.
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> Health and Safety Code section 1367 establishes significant standards for the delivery and quality of health care services by health plans, including broad requirements for delivering care in a timely manner as appropriate for each enrollee's health care needs, and consistent with good professional practice. Subsection (d) of section 1367 requires that plans 'shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.' Prior to the enactment of AB 2179, subsection (e)(1) of section 1367 required that 'All services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees. AB 2179 amended subsection (e)(1) to require, 'All

services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.' (Underline added to reflect the new language added by AB 2179.)

AB 2179 made another notable amendment to section 1367, by adding the following clarification regarding the ultimate obligation of health plans to comply with the standards and requirements of section 1367. 'The obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.'

Health and Safety Code section 1367.01, regarding health plan utilization review processes, and Civil Code section 3428, establishing a cause of action for ordinary negligence for a health plan's breach of the duty of ordinary care in performing utilization review, are important provisions relevant to the development of these regulations.

Necessity

Adoption of Section 1300.67.2.2 remains necessary to implement, clarify, and make specific the requirements of Health and Safety Code section 1367.03 (Section 1367.03) as described in the initial Notice of Rulemaking Action published on January 9, 2009. As explained in the Department's Notice of Rulemaking Action and the Initial Statement of Reasons, Section 1367.03 expressly instructs the Department to develop and adopt regulations 'to ensure that enrollees have access to needed health care services in a timely manner' and directed the Department to develop indicators of timeliness of access to care including three indicators specified in subsection (a)(1)-(3) of Section 1367.03. Subsection (b) of Section 1367.03 further directs the Department to consider specified factors in developing standards for timeliness of access to care. Subsection (c) of Section 1367.03 permits the Department to adopt standards other than the time-elapsed from the time an enrollee first seeks care and obtains it, if the Department demonstrates why that standard is more appropriate.

AB 2179 also required the California Department of Insurance (CDI) to adopt regulations, although the legislature described a different approach for the CDI than it outlined for the Department. The Department has consulted with CDI regarding the development of these regulations, consistent with Section 1342.4, to assess the potential for consistency in developing the respective regulations.[5]

[5] The CDI added geographic accessibility standards (distance metrics) to its existing regulations. The geographic access standards added by the CDI for primary care physicians and hospitals are consistent with the Department's geographic access standards for those categories of services. The CDI also added geographic access standards for specialist physicians and mental health care providers. These regulations do not modify existing Knox-Keene geographic access standards, which do not include standards for specialist physicians and mental health care providers. The Department's approach, as required by Section 1367.03, is directed to address the waiting times for services. Sections 1300.51(d)(Exhibit H), 1300.67.2 and 1300.67.2.1, title 28, California Code of Regulations. Additional consistency between CDI regulations and DMHC regulations may be found in physician-to-enrollee ratio requirements: one full time

> The course of this rulemaking action has been highly complex and controversial, with interested and affected persons very polarized in their views about the best approach to establish standards for timeliness of access to health care services. The extreme complexity and serious polarization of the interested persons participating in the development of this regulation resulted in the submission of many different alternatives by the interested persons. The alternatives proposed to and considered by the Department are captured in the public comments collected during four public comment periods, and in the Department's responses to each of the public comments.
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> The final revised regulation text remains true to the legislative intent and mandate reflected in Section 1367.03, while accomplishing the difficult task delegated to the Department by the Legislature, that is, to balance the competing concerns among affected persons, to accomplish sensible, workable and meaningful regulations designed to ensure timely access to care for enrollees. The necessity for the provisions in the final revised text and for the changes made to the text that was initially published, is explained in the Final Statement of Reasons.
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> The final revised regulation text reflects substantial changes that are sufficiently related to the original text and within the scope of the Notice of Rulemaking Action. Accordingly, consistent with APA requirements, the Department made the revised text available for public comment. A reasonable member of the directly affected public could have determined from the Notice that these changes to the regulation could have resulted."

On November 3, 2009, the final regulation package was submitted to the Office of Administrative Law (OAL). The regulation was approved by OAL[6] and filed with the Secretary of State on December 18, 2009. The regulation was effective on January 17, 2010.[7]

5. SUBSTANTIAL CONTRIBUTION

Health and Safety Code section 1348.9, subdivision (a) provides that:

> "[T]he director shall adopt regulations to establish the Consumer Participation Program, which shall allow for the director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation...." (Emphasis added).

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equivalent primary care physician for every 2000 enrollees; and one full time equivalent physician for every 1,200 enrollees.

[6] Office of Administrative Law, Notice of Approval of Regulatory Action, OAL File No. 2009-1103-04 S, December 18, 2009.

[7] *Id.*

The definition of "Substantial Contribution" provides the criteria for evaluating whether the Participant has made a Substantial Contribution.[8] 28 CCR § 1010(b)(8) defines "Substantial Contribution" as follows:

> "'Substantial Contribution' means that the Participant significantly assisted the Department in its deliberations by presenting relevant issues, evidence, or arguments which were helpful, and seriously considered, and the Participant's involvement resulted in more relevant, credible, and non-frivolous information being available to the Director."

5.1 APPLICATION MUST INCLUDE DESCRIPTION OF CONTRIBUTION

The application for an award of compensation must include "a description of the ways in which the Participant's involvement made a Substantial Contribution to the proceeding [9]..., supported by specific citations to the record, Participant's testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence." 28 CCR § 1010(e)(2)c.

5.2. APPLICANT'S DESCRIPTION OF ITS CONTRIBUTION

APPLICANT submitted the following information, documents and testimony in support of its position regarding the proposed adoption of the proposed regulation and regulation changes:

> "Western Center on Law and Poverty, over a four-year period, tenaciously and successfully advocated to improve proposed Department of

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[8] Further guidance is provided in PUC Decisions awarding intervenor compensation. For example:

> "In evaluating whether ... [an intervenor] made a substantial contribution to a proceeding, we look at several things. First, did the ALJ or Commission adopt one or more of the factual or legal contentions, or specific policy or procedural recommendations put forward by the ... [intervenor]? ... Second, if the ...[intervenor's] contentions or recommendations paralleled those of another party, did the ...[intervenor's] participation materially supplement, complement, or contribute to the presentation of the other party or to the development of a fuller record that assisted the Commission in making its decision? ... [T]he assessment of whether the ...[intervenor] made a substantial contribution requires the exercise of judgment.
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> "In assessing whether the ...[intervenor] meets this standard, the Commission typically reviews the record, ... and compares it to the findings, conclusions, and orders in the decision to which the ...[intervenor] asserts it contributed. It is then a matter of judgment as to whether the ..[intervenor's] presentation substantially assisted the Commission. [citing D.98-04-059, 79 CPUC2d 628, 653 (1998)].
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> Should the Commission not adopt any of the ...[intervenor's] recommendations, compensation may be awarded if, in the judgment of the Commission, the ...[intervenor's] participation substantially contributed to the decision or order. For example, if ...[an intervenor] provided a unique perspective that enriched the Commission's deliberations and the record, the Commission could find that the ...[intervenor] made a substantial contribution." PUC Decision D.06-11-031 (November 30, 2006), PP. 5 - 6; similarly, D.06-11-009 (November 9, 2006), pp. 7 - 8.

[9] Decisions under the PUC's Intervenor Compensation Program go further and require intervenors to assign a reasonable dollar value to the benefits of the intervenor's participation.

> "D.98-04-059 directed ...[intervenors] to demonstrate productivity by assigning a reasonable dollar value to the benefits of their participation to ratepayers. The costs of ...[an intervenor's] participation should bear a reasonable relationship to the benefits realized through their participation. This showing assists us in determining the overall reasonableness of the request." D.06-11-031 (November 30, 2006), p. 11; D.06-11-009 (November 9, 2006), pp. 31 - 32.

Managed Health Care regulations concerning timely access to health care. Western Center now seeks an award of advocacy fees totaling $47,785 ... because of its substantial contribution to the final regulations; and the amount sought is reasonable.

Health & Safety Code § 1348.9(a) permits DMHC to award reasonable advocacy fees when an organization representing the interests of consumers 'has made a substantial contribution of behalf of consumers to the adoption of any regulation . . . .' Western Center contributed substantially to the final regulations on Timely Access to Health Care Services, and is thus entitled to a fee award.

When amendments to the timely access regulations were first proposed in 2006, Western Center attorney and legislative advocate Elizabeth Landsberg began working on this matter. On behalf of a number of legal services organizations around the state coordinated and drafted comments to the draft regulations that were issued in March of 2007. (The written comments and other documents that we submitted to the Department since 2007 are attached ... [hereto]).

The comments submitted noted that the time allowed for dental care, in particular the 180-day time limit for preventative care, was too long, along with the time limits on urgent mental health care. She also offered specific suggestions regarding timely telephone access, compliance monitoring, language access, and the alternative standards.

Another round of regulations was issued in September of 2007. One of our suggestions regarding the compliance monitoring - that is, ensuring that a statistically valid provider survey was used - was adopted in the new round of regulations. Ms. Landsberg again coordinated and drafted the comments on behalf of a number of organizations and raised a number of concerns, including concerns about the primary care standards, prohibitions on requiring providers to maintain records on compliance with telephone access standards, and necessary clarifications on enrollee education.

In December 2007, the Department radically changed course and issued a set of regulations that allowed individual health plans to determine what timely access is. Ms. Landsberg again coordinated and drafted comments on behalf of a number of organizations informing the Department that this new approach directly violated the authorizing statute. Nonetheless, the Department moved to finalize these regulations.

At this time, Western Center found the violation so substantial that we agreed to represent another organization in suing the Department for violating the law. Fortunately, the regulations were not finalized as the Office of Administrative Law found that the Department had violated procedural requirements on comment periods. Shortly thereafter, on March 27, 2008, Ms. Landsberg was called before the Senate Health Committee to testify on how the Department conducted the regulatory process and to what extent it considered consumer input.

Western Center was subsequently invited to a Timely Access Regulations Stakeholder meeting on June 30, 2008, in which Ms. Landsberg participated. At that meeting, we were asked to draft our proposals as to how various aspects of the Timely Access regulations should work. Ms. Landsberg and Western Center attorney Jen Flory drafted one of the consumer proposals

together with Ann Rubinstein of Health Rights Hotline. We were then asked to review and comment on the proposals of other Organizations, which we did, informing the department where the other proposals failed to protect the consumers or comply with the law. Ms. Landsberg then attended three meetings held by the Department in September, 2008 regarding the various proposals. In late October, 2008, she met with Department officials regarding informal draft of the revised regulations.

Western Center submitted comments on the informal regulations. At this time the Department incorporated the time-elapsed standards and some of our language access considerations as requested by Western Center and other consumer groups during the proposal process. We also raised a number of concerns including the inclusion of alternative timeliness standards and the nonstandard compliance monitoring requirements. We also offered technical corrections in the regulatory language.

When new regulations were formally issued in February 2009, Western Center again provided comments on behalf of a number of organizations regarding the timeliness for urgent care, dental and specialty care, language access, and compliance monitoring. As these regulations were similar to the informal regulations we had seen in November, our comments were similar as well.

The regulations were again revised in Spring of 2009 and we submitted comments solely on the revisions that June. A final set of regulations was issued and we submitted our comments in October 2009. Again, we limited these comments to the revisions, in particular on compliance standards.

The Timely Access to Care Regulations went into effect this past January. Were it not for our participation, in coordination with other consumer groups, the regulations would have allowed individual health plans to essentially monitor themselves. Dental, vision, chiropractic, acupuncture and specialty mental health plans would have been largely exempted or had much lighter standards. Requirements on appointments with specialists would have offered longer wait times. Coordination with interpreter services at the time of appointment would not have been included. Telephone answering services after hours would not have been required to notify enrollees how to get triage services to determine whether a trip to urgent care was required. Plans could have asked for alternative timeliness standards without adequately demonstrating why such standards were appropriate. Western Center devoted considerable time in providing the Department with both legal support for our positions and an explanation of the practical effect the Department's actions would have on consumers.

In short, Western Center significantly improved the timely access regulations and therefore should be awarded advocacy fees."

APPLICANT submitted the following documents in support of its description of Substantial Contribution:

Western Center supporting document dated 3-5-2007
Western Center supporting document dated 9-21-2007
Western Center supporting document dated 12-21-2007
Western Center supporting document dated 3-27-2008

Western Center supporting document dated 7-24-2008
Western Center supporting document dated 8-21-2008
Western Center supporting document dated 11-21-2008
Western Center supporting document dated 2-23-2009
Western Center supporting document dated 6-25-2009
Western Center supporting document dated 10-13-2009

5.3 PROCEDURAL VERIFICATION OF SUBSTANTIAL CONTRIBUTION

Proceeding Control No. 2002-0018

Representatives of APPLICANT did not participate in the Public Hearing on August 16, 2004 or present comments in the extended period for public comments that closed on November 8, 2004. Thereafter, the Department issued notice of its decision not to proceed with the rulemaking action of Proceeding Control No. 2002-0018.

APPLICANT's representatives reviewed discussion drafts, conferred with other consumer advocates, and participated in stakeholder meetings conducted by the Department in October 2006, in order to improve the quality of provisions to be included in a timely access regulation to be proposed. APPLICANT's representatives prepared key areas of concern and outlined questions and concerns to present to the Department. In preparation for participation in the stakeholder meetings, APPLICANT's representatives reviewed a document distributed by the Department on proposed timely access to care regulation provisions.

Proceeding Control No. 2005-0203

On March 5, 2007, a Staff Attorney/Legislative Advocate of APPLICANT testified at a Public Hearing on the proposed regulation.

By letter dated March 5, 2007, APPLICANT's staff presented written comments on the proposed regulation, signed by the Staff Attorney/Legislative Advocate of APPLICANT and on behalf of National Health Law Program, Neighborhood Legal Services' Health Consumer Center of Los Angeles, Protection & Advocacy, Inc., and Health Consumer Center of San Mateo. That submission contained approximately six comments, including expressions of support for certain provisions, presentation of analysis of hypothetical fact situations illustrating why the provisions were needed, and recommendations requesting changes. APPLICANT stated in summary:

(1) The time standards for dental care are too long. The time for urgent dental care should be changed from 48 to 24 hours. A consumer in intense pain from an infected tooth should not be expected to wait two days for an appointment. Similarly, the timeframes for routine and preventive dental care should be set at 14 days and 60 days respectively.

(2) The time standard for urgent mental health is too long and should be changed from 48 to

24 hours. Conforming the standard for urgent mental health with the standard for urgent physical health is in keeping with the mental health parity law. Serious mental illness should not be treated differently from physical health needs. The Department should consider conformity with the Medi-Cal mental health standards for urgent care which require that mental health services to treat a member's urgent condition be available 24 hours a day, seven days per week

(3) The telephone time standard applicable where a provider uses a recorded message requires that the provider "attempt to contact the enrollee in a timely manner consistent with good professional practice." That vague standard does not ensure timely telephone access. In the age of answering services, pagers, cellular telephones and other technologies, it is unreasonable that a consumer in need of triage to determine whether a condition is urgent not be able to reach a live person within 30 minutes. Suggested language was provided.

(4) Satisfaction surveys and reviewing grievances are insufficient to monitor compliance with timely access standards. For providers not operating on a same-day appointment basis, plans should either audit actual provider records or do secret shopper telephone surveys of provider offices. The provision in the proposed regulation that would allow a plan that demonstrated full compliance in one year to not submit all the elements of annual compliance the following year should be deleted. The following compliance monitoring tools should be done in multiple languages to comply with language access requirements: enrollment satisfaction surveys, disenrollment surveys, non-anonymous telephone surveys of providers' offices, and anonymous (secret shopper) telephone audits of providers' offices.

(5) The regulation should incorporate language access requirements in the appointment and telephone standards. Timely access to care is a particular problem for limited English proficient (LEP) consumers. The proposed regulation should specify application to LEP patients because the potential delay posed by obtaining language assistance services, such as an interpreter, is greater, and there are no timely access standards in the current Language Assistance Program regulations. At a minimum, any time delays for LEP enrollees must not be any longer than those for non-LEP enrollees. Compliance monitoring should include the demographic profile of the plan's enrollee population. The language of the regulation should make it clear that the plan and/or provider must ensure present capacity to provide language assistance services and cannot simply claim lack of capacity. In addition, there should be a requirement for materials to be translated into other languages upon request, completed within 21 days.

(6) A global cap should be adopted on the number of patients for whom one primary care

physician is responsible to manage care. The ratio of one primary care physician for each 2,000 enrollees is largely meaningless if that same physician can contract with four different health plans, each with 2,000 enrollees for a total of 8,000 patients. A global ratio is the only effective way to ensure that providers do not contract with multiple health plans and cumulatively have more patients assigned to them than they can effectively and timely serve.

On September 18, 2007, a Staff Attorney/Legislative Advocate of APPLICANT testified at a Public Hearing on the proposed regulation.

By letter dated September 21, 2007, APPLICANT's staff presented written comments on the proposed regulation, signed by the Staff Attorney/Legislative Advocate of APPLICANT and on behalf of National Health Law Program, Neighborhood Legal Services' Health Consumer Center of Los Angeles, and Protection & Advocacy, Inc. That submission contained approximately ten comments, including expressions of support for certain provisions, presentation of analysis of hypothetical fact situations illustrating why the provisions were needed, and recommendations requesting changes. Eight of APPLICANT's comments suggested changes. APPLICANT stated in summary:

(1) Strenuous disagreement was expressed that the Department should "take a step back" and appoint a commission of stakeholders to rethink the approach suggested by numerous speakers at the Public Hearing held on September 18, 2007. All stakeholders have had ample time to come forward with alternative approaches. The I-know-it-when-I-see-it standard proposed by some stakeholders is not in any way measurable or enforceable.

(2) Urgent care centers should not replace the need for consumers to have a medical home with a primary care provider. In most cases, an urgent care center will not have a consumer's medical records and will not have an established relationship with the consumer. Therefore, such centers should be used only for urgent care appointments. If the regulation allows non-urgent, primary care to be provided through an urgent care center, the regulation must specify that the consumer will not incur more cost sharing than if the consumer was seen by the consumer's primary care physician. "Medical home" should be defined, and the primary care appointment standard should state that an urgent care appointment can be made at an urgent care center only if there is no appointment time available with the consumer's primary care physician or medical home.

(3) The time standards for dental appointments continue to be too long. The time for urgent dental care should be changed from 48 to 24 hours. Timeframes for routine and preventive dental care should be set at 12 business days and 60 calendar days, respectively.

(4) Strenuous objection was made to the proposed 48-hour standard for urgent mental health care. Urgent mental health appointments should be given within 24 hours, conforming the standard to urgent physical health needs in keeping with the mental health parity law. In addition, all health plans should be required to have a mental health professional available 24 hours a day, seven days a week to speak to members in crisis.

(5) Objection was made to "demoting" telephone waiting times from standards to guidelines. The new exception to the fifteen minute telephone waiting time "if no ... qualified professional is available" renders the fifteen minute standard meaningless by conveying that a consumer can talk to someone within fifteen minutes unless no one is available. Where answering machines are used, language should be added requiring that providers instruct patients how to reach someone, especially when patients need to consult with their provider to determine whether their condition requires urgent care.

(6) The proposed compliance is fundamentally flawed due to reliance solely on consumer complaints and non-anonymous surveys. Anonymous surveys would be more reliable. The new language in the proposed regulation that prohibits plans from requiring providers to maintain records of compliance with various standards violates the authorizing statute and undermines the goal of ensuring timely access to care. In addition, the regulation should specify that specified compliance monitoring tools be implemented in multiple languages to comply with language access requirements.

(7) It was again recommended that the regulation contain coordination and cross-reference between timely access and the Language Assistance Program regulation. APPLICANT reiterated prior recommendations for implementing language assistance services and adding time requirements regarding the translation of materials into other languages upon request (completion within 21 days).

(8) The regulation should be strengthened to require that the plans' evidences of coverage include actual timely access standards, information about how enrollees can obtain the plan's help in getting a timely appointment, and how to file a complaint, especially if compliance with timely access standards will rely on consumer complaints.

By letter dated December 21, 2007, APPLICANT's staff presented written comments on the proposed regulation, signed by the Staff Attorney/Legislative Advocate of APPLICANT and on behalf of National Health Law Program, Neighborhood Legal Services' Health Consumer Center of Los Angeles, Community Health Advocacy Project, Bay Area Legal Aid, Fresno Health Consumer Center, Central California Legal Services, Inc., and Consumer Center for Health Education & Advocacy, Legal Aid Society of San Diego. APPLICANT expressed dismay at "... the radical

departure the latest proposed regulations take from earlier approaches. The Department has gone from thorough regulations which would have given clear guidance to consumers and providers alike regarding what timely access to care is in different areas and required statistically significant compliance monitoring and replaced them with an approach which leaves it up to individual health plans to decide what timely means." In addition, APPLICANT's letter stated: "The current proposed regulations do not fulfill the statutory requirements of AB 2179 (Health & Safety Code § 1367.03). ... Rather than providing clear standards as required, these proposed regulations are a shadow of their former self and leave it up to the various health plans to decide what is timely for a given type of care. ... It is baffling indeed that the Department would abandon the previously proposed clear standards while still conceding that there are professionally recognized standards. We cannot see this as anything but an abdication of the Legislature's charge to develop indicators of timely care." APPLICANT strenuously urged the Department to return to the previous approach of laying out specific time-elapsed standards applicable to all health plans. APPLICANT's submission contained approximately six comments. APPLICANT stated in summary:

(1) It is deeply troubling that the Department has abandoned standards for dental, vision, acupuncture and chiropractic care. Full-service plans are not required to have standards for these health care services and specialty plans are no longer subject to any timeliness standards. APPLICANT implored the Department to include timeliness standards for dental care and include standards for vision, acupuncture and chiropractic care.

(2) Regarding telephone triage access, the requirement that during non-office hours, a triage line must only "provide clear recorded instructions regarding how to obtain urgent or emergency care" is vague. It is unacceptable for a consumer not to be able to reach a triage doctor or nurse for guidance on whether to seek urgent or emergency care. APPLICANT continued to request that providers be required to advise patients how to reach a qualified professional who is trained to screen and triage.

(3) Regarding compliance monitoring, the latest version of the regulation scraps the careful work based on statistically valid survey methodology. Instead, plans would monitor their own set timeliness standards through: an annual enrollee satisfaction survey; an annual provider satisfaction survey; and monthly review of enrollee complaints and grievances, monitoring of provider performance and screening and triage. APPLICANT urged the Department to return to the statistically valid survey method.

(4) Regarding out-of-network provider access, if a consumer cannot get medically necessary care in a timely manner, the plan should be required to find an appointment with an out-of-plan provider.

(5) Again, the Department was urged to follow through with coordination of timely access regulations and Language Assistance Plan regulations.

(6) The Department was urged to rethink is current approach and return to specific time-elapsed standards to effectuate the requirements of the timely access Statute.

Of the March 5, 2007, September 21, 2007, and December 21, 2007, comments requesting changes, all were reviewed, but all were neither accepted nor declined because the OAL, by decision dated March 5, 2008, disapproved the newly-proposed regulation, and the Department did not proceed further with the rulemaking action of Proceeding Control No. 2005-0203.

From June to September 2008, representatives of APPLICANT participated in stakeholder meetings to help shape the future of the timely access regulations.

With a memorandum dated July 24, 2008, APPLICANT submitted proposals for the timely access to care regulations, in chart form and covering seven major issues.

With a memorandum dated August 21, 2008, APPLICANT submitted responses to seven issues identified by the Department for the timely access to care regulations, in chart form.

APPLICANT's participation in the informal stakeholder process included comments provided by letter dated November 21, 2008. That submission contained approximately nine comments, including expressions of support for the Department's return to regulations based on time-elapsed standards as the only measures that meet the statutory requirement and ensuring that LEP consumers have access to an interpreter within the time-elapsed standards. The submission contained comments to strengthen the regulatory requirements and oversight by the Department, and provided supporting arguments and information. APPLICANT stated in summary:

(1) Concerns were expressed about exempting or applying different standards to dental and visions plans, the lack of uniform and objective standards for compliance monitoring, and allowing plans to effectively opt out of compliance entirely by permitting them to write their own alternative standards to the time-elapsed standards.

(2) Concern was expressed that the proposed regulation does not apply the time-elapsed standards or requirement for telephone triage services to dental, vision, chiropractic, and acupuncture plans. The Department must ensure that enrollees in all the plans it regulates – full-service and specialty plans – have timely access to care by imposing the same standards. The Department should not waive applicability to specialized plans.

(3) A language change was recommended to ensure that the right to an interpreter is read in conjunction with other timeliness standards. It was recommended that language access requirements be incorporated into the Quality Assurance Processes and Enrollee Disclosures and Education.

(4) Regarding triage and screening services, dental and vision plans should be required to ensure that their enrollees have access to a qualified professional who is trained to screen and triage. There should not be a different triage standard for certain types of specialty plans.

(5) Strong objection was expressed regarding the quality assurance processes that still grant health plans far too much discretion in determining their own compliance with the timely access standards. If each plan uses a different methodology, consumers will have no way of comparing the results against each other as required by Health & Safety Code § 1367.03(f)(2) which provides that "the reported information shall allow consumers to compare the performance of plans and their contracting providers in complying with the standards, as well as changes in the compliance of plans with these standards." All plans should be subject to the same uniform and objective standards, such as anonymous telephone audits of providers. The current version of the regulation has no measurable standards for corrective actions, and thus does nothing to protect consumers. The regulation should have specific standards for corrective action plans in the event of non-compliance, such as respond immediately and correct deficiencies within 60 days.

(6) Contracts between plans and providers should assure compliance with the timely access standards and require reporting by health care providers to health plans. The proposed regulation should at least minimally outline what provider reports should contain and how often they should be done.

(7) Regarding enrollee disclosure and education, information should be provided to enrollees in the appropriate language in accordance with the Language Access provisions.

(8) Regarding alternative time-elapsed standards, strong opposition was expressed to any alternatives for time-elapsed standards being done on a plan-by-plan basis. To allow some plans to opt out of the timely access standards and set their own completely eviscerates the intent of the Legislature and the ability of consumers to compare plans. The timely access statute does not give health plans the authority to set their own standards. This subsection should be deleted in its entirety.

(9) Regarding provider access where there is a shortage of a type of provider, plans must ensure compliance with the timeliness standards by arranging the care with an out-of-area or out-of-network provider rather than merely "refer" the consumer to a provider who may or may not be willing to see the consumer. In addition, language should be added to ensure that the enrollee is not

charged more than the enrollee's usual cost sharing if the enrollee is forced to go out of network because of the lack of providers, and such arrangements must be documented in writing and given to the enrollee before or at the time of treatment as care out-of-network is inherently vulnerable to billing errors or disputes.

Proceeding Control No. 2008-1579

By letter dated February 23, 2009, APPLICANT's staff presented written comments on the proposed regulation, signed by the Staff Attorney of APPLICANT and on behalf of National Health Law Program. That submission contained approximately ten comments, including comments with recommendations requesting changes, reiteration of previous recommendations and concerns, and supporting argument and information to assure that the intent of the Legislature is met. APPLICANT stated in summary:

(1) Serious concern was expressed over the increased timeframe for urgent care not requiring prior authorization to 48 hours instead of the 24 hour timeframe previously urged, particularly in view of the definition of urgent care in Health & Safety Code § 1367.01(h)(2). A consumer with an urgent primary health, mental health, or dental need may not be able to wait more than a day before suffering serious harm to their health. Concern was also expressed over the timeframe for urgent care appointments requiring prior authorization being extended to 96 hours, instead of the previous standard of 72 hours. APPLICANT expressed being perplexed about what type of urgent care would require prior authorization. It was recommended that the provision allowing extension of the applicable waiting time be modified to include a requirement that the health care provider or triage services provider document that a longer waiting time will not cause additional pain or health problems to the enrollee.

(2) Timely access standards must apply to all health plans, including specialized health plans, including vision, chiropractic, and acupuncture plans. The Department should ensure that enrollees in all the plans it regulates have timely access to care by imposing the same standards both in appropriate wait times and in compliance monitoring to ensure that plans are abiding by the time-elapsed standards. It was again urged that all urgent care be provided within 24 hours and not the 72 hours permitted for dental care. Concern was expressed about the 7-week standard for non-urgent dental care, which is a long time to wait to have a cavity filled even if it has not yet caused an infection or toothache rendering it an urgent condition.

(3) It was again recommended that language access requirements be incorporated into the Quality Assurance Processes and Enrollee Disclosures and Education.

(4) Regarding triage and screening services, language should be added to clarify that if a provider uses email as a way for consumers to communicate with a trained health care professional, the provider must respond within 10 minutes. One telephone time standard that does not ensure timely access is the standard that requires dental, vision, chiropractic and acupuncture plans to have a telephone service or machine with instructions on how to obtain urgent care, when applicable. Use of the phrase "when applicable" suggests that not all providers would have to provide a number for a provider to provide triage and screening services. All plans should be required to ensure that their enrollees have access to a qualified professional who is trained to screen and triage.

(5) Regarding compliance monitoring, strong objection was made to the quality assurance processes that still grant health plans far too much discretion in determining their own compliance with the timely access standards. It was again asked that all plans be subject to the same uniform and objective standard, such as anonymous telephone audits of providers. In the event that enrollee surveys are conducted, vulnerable populations, such as LEP and communities of color, must be targeted specifically as these communities often have greater barriers to accessing care in a timely manner and are often less likely to complain when they cannot. In addition, any surveys must be translated into the plans' threshold languages. The regulation should have specific standards for corrective action plans in the event of non-compliance, such as respond immediately and correct deficiencies within 60 days.

(6) It was again urged that contracts between plans and providers should assure compliance with the timely access standards and require reporting by health care providers to health plans. The proposed regulation should at least minimally outline what provider reports should contain and how often they should be done.

(7) Regarding enrollee disclosure and education, the member's card should have both the customer service number and the triage number so that enrollees may know about the availability of telephone triage services and how to access them. It was also asked that such information be provided to enrollees in the appropriate language in accordance with the Language Access provisions.

(8) Regarding alternative time-elapsed standards, strong opposition was again expressed to any alternatives for time-elapsed standards that are done on a plan by plan basis. To allow some plans to opt out of the timely access standards and set their own completely eviscerates the intent of the Legislature and the ability of consumers to compare plans. The timely access statute does not give health plans the authority to set their own standards. This subsection should be deleted in its entirety.

(9) The timely access regulation must apply to Medi-Cal and Healthy Families plans. Opposition was expressed for creating a separate tier of consumer protections for Medi-Cal and Healthy Families enrollees where there may be fewer protections than other persons using managed care.

(10) Regarding provider access where there is a shortage of a type of provider, it was again urged that plans must ensure compliance with the timeliness standards by arranging the care with an out-of-area or out-of-network provider rather than merely "refer" the consumer to a provider who may or may not be willing to see the consumer. In addition, language should be added to ensure that the enrollee is not charged more than the enrollee's usual cost sharing for going out of network because of the lack of providers, and such arrangements must be documented in writing and given to the enrollee before or at the time of treatment as care out-of-network is inherently vulnerable to billing errors or disputes.

By letter dated June 25, 2009, APPLICANT's staff presented written comments on the proposed regulation, signed by the Staff Attorney and Staff Attorney/Legislative Advocate of APPLICANT. That submission contained approximately four comments, including expressions of support for certain provisions and presentation of analysis of hypothetical fact situations illustrating why the changes were needed. APPLICANT stated in summary:

(1) Disappointment was expressed regarding lack of acceptance of the prior suggestion that the 48-hour urgent care timeliness standard be shortened.

(2) Concern was expressed that the time limit for triage and screening services was raised from ten minutes to thirty minutes which is too long for a patients to wait for advice on whether they have an urgent condition. Patients should not have to wait 30 minutes on hold and be punished for their efforts to avoid high cost emergency room medical care or to remain within their own health plans by a thirty-minute wait when they are sick or injured and do not know the seriousness of their condition. A shorter period is more reasonable and would be more likely to reduce inappropriate emergency room utilization.

(3) Regarding Evidence of Coverage ("EOC") disclosure, the plan's timely access standards should be in the EOC and not merely placed in plan newsletters or other enrollee communications. The EOC is a basic reference material for enrollees and important rights should be included. Not communicating timely access standards to consumers in the EOC will undermine their purpose and the compliance monitoring process which relies in part on consumers having that knowledge in order to make consumer complaints.

(4) Regarding PPO network compliance monitoring, a technical subsection renumbering error was identified.

By letter dated October 13, 2009, APPLICANT's staff presented written comments on the proposed regulation, signed by the Staff Attorney and the Staff Attorney/Legislative Advocate of APPLICANT, and on behalf of National Health Law Program, Neighborhood Legal Services, Health Rights Hotline, and Fresno Health Consumer Center. That submission contained approximately four comments with recommendations requesting changes. APPLICANT stated in summary:

(1) Disappointment was expressed regarding compliance reporting required to be filed by health plans being moved back a year to March 31, 2012, and the reporting period being moved back to 2011. Much of the benefit to consumers has been delayed for a decade.

(2) Disappointment was also expressed regarding the standard allowing for recording extension of the timely access standards being downgraded from requiring the professional to only "note" that the additional time will not have detrimental impact on the enrollee's health rather than "document" this information. This is a lesser standard. As a waiver of consumers' rights, sufficient documentation of the rationale behind such waiver should be required, not just a note in the margin. The strongest language should be used by the provider to document exceptions to timely access.

(3) The clause "or the health professional providing triage or screening services" should be deleted because it appears to allow such services to be provide by an unlicensed professional. The screening and triage function should be performed by licensed medical professionals to avoid any possibility of adverse health consequences to patients that may result from use of unlicensed personnel in the medical screening process.

(4) Revisions to the regulation regarding compliance monitoring move in the direction of allowing plans to self-monitor in a subjective fashion and lack uniformity that could help consumers compare plans. By using only provider and enrollee reporting, reliable statistics will not be created because providers have no incentive to report their failures and enrollees may underreport problems. Audits by outside entities, or at the very least, enrollee surveys based on Department-defined sampling and scripts would ensure more accurate reporting.

Of the February 23, 2009, June 25, 2009, and October 13, 2009, comments requesting changes, all were reviewed, some were accepted, some were declined, and some were neither accepted nor declined. The rulemaking action of Proceeding Control No. 2008-1579 resulted in the regulation being filed with the Secretary of State to become effective.

5.4. FINDING OF SUBSTANTIAL CONTRIBUTION

The Hearing Officer finds that participation by APPLICANT: (1) significantly assisted the Department in its deliberations by presenting relevant issues, evidence, and arguments that were helpful and seriously considered, and (2) resulted in more relevant, credible, and non-frivolous information being available to the Director to make her decision regarding the proposed adoption of 28 CCR §1300.67.2.2 than would have been available to the Director had APPLICANT not participated.

The Hearing Officer hereby determines that by its participation APPLICANT made a substantial contribution on behalf of consumers to the proceedings, to the Department in its deliberations, and as a whole, to the adoption of 28 CCR §1300.67.2.2.

The Hearing Officer finds that APPLICANT has made a Substantial Contribution, pursuant to 28 CCR § 1010(b)(8), to the timely access rulemaking proceeding.

6. REASONABLENESS OF HOURS AND COSTS AND MARKET RATE

Health and Safety Code section 1348.9 allows the Director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of a regulation.

6.1. FEES AND COSTS REQUESTED

APPLICANT billed the following time, hourly rates, and fees for its representatives.

Staff / Title	Hours	Rates	Fees
Staff Attorney/Legislative Advocate			
-- Work in 2006	12.1	$415.00	$5,021.50
-- Work in 2007	32.9	$415.00	$13,653.50
-- Work in 2008	42.6	$415.00	$17,679.00
-- Work in 2009	4.6	$415.00	$1,909.00
Staff Attorney -- Work in 2008	19.7	$325.00	$6,402.50
-- Work in 2009	9.6	$325.00	$3,120.00
TOTAL FEES	→		**$47,785.50**

APPLICANT did not claim or bill for any expenses or recoverable costs.

6.2. CONSIDERATIONS USED IN PUC'S INTERVENOR COMPENSATION PROGRAM

Reference to the Intervenor Compensation Program of the California Public Utilities Commission ("PUC") seems appropriate because it is similar to the Department's Consumer

Participation Program[10] and has an extensive history of awarding intervenor compensation and updating hourly rates used in computing awards of compensation to intervenors who make substantial contributions to PUC decisions.

In each proceeding before the PUC in which intervenors participate, the PUC issues a written opinion setting forth the decision regarding award of intervenor compensation. Therefore, the many PUC written decisions granting intervenor compensation provide a valuable source of guidelines to determine reasonableness and market value. Some of the common threads of the PUC decisions are summarized as follows.

In considering an intervenor organization's request for compensation, the PUC opinions have:

a. Separately considered and approved the individual hourly rate of compensation for each of the intervenor's experts and advocates.[11]

b. Awarded the same rate for an individual expert that was approved in a prior proceeding in the same year,[12] and have declined to approve a requested increase in hourly rate for an expert over the rate approved in a prior proceeding in the same year.[13]

c. Awarded increases of three percent (3%) rounded to the nearest $5 over the prior year when increase in hourly rates is requested by the intervenor organization or where the hourly rate for an individual expert or advocate was approved in the prior year and an increase is considered warranted for the current year.[14] The PUC has consistently rejected requests for increases over 3%.[15]

d. Stated that documentation of claimed hours by presenting a daily breakdown of hours accompanied by a brief description of each activity reasonably supported the claim for total hours.[16]

e. Approved compensation for travel time at one-half the normal hourly rate.[17]

f. Approved compensation for preparation of the intervenor organization's compensation request or compensation claim at one-half the normal hourly rate.[18] However, administrative costs

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[10] The Legislative history behind the Department's Consumer Participation Program specifically referred to the PUC's program.

> "The Legislature finds and declares that consumer participation programs at the Public Utilities Commission and the Department of Insurance have been a cost-effective and successful means of encouraging consumer protection, expertise, and participation...." Stats 2002 C. 792 § 1 (SB 1092).

[11] PUC Decision (D.) 06-11-031 (November 30, 2006).
[12] D.06-11-031 (November 30, 2006).
[13] D.06-11-032 (November 30, 2006), pp. 10 – 11.
[14] D.06-11-031 (November 30, 2006), p. 11.
[15] D.06-11-031 (November 30, 2006), p. 11.
[16] D.06-11-031 (November 30, 2006), p. 10.
[17] D.06-11-031 (November 30, 2006); D.06-11-032 (November 30, 2006), p. 8, fn. 4.
[18] D.06-11-031 (November 30, 2006), p. 9, fn. 2; D.06-11-032 (November 30, 2006), p. 8, fn. 4.

are considered non-compensable overheads, and therefore, the PUC has disallowed time charged by an intervenor's office manager for gathering expense data for the compensation claim.[19]

g. Approved compensation for efforts that made a substantial contribution even where the PUC did not wholly adopt the intervenor's recommendations.[20]

h. Approved payment of itemized direct expenses where the request shows "the miscellaneous expenses to be commensurate with the work performed," including costs for photocopying, FAX, Lexis research, postage, courier, overnight delivery, travel, and parking.[21]

i. Reminded intervenors of the requirements for records and claim support, and that PUC staff may audit the records – for example:

> "We remind all intervenors that Commission staff may audit their records related to the award and that intervenors must make and retain adequate accounting and other documentation to support all claims for intervenor compensation. [Intervenor's]... records should identify specific issues for which it requested compensation, the actual time spent by each employee or consultant, the applicable hourly rate, fees paid to consultants, and any other costs for which compensation was claimed."[22]

j. Disallowed time where the "hours seem excessive" or the "proposal is not persuasive,"[23] and have changed or disallowed compensation amounts requested for the following reasons:[24] "Excessive hourly rate; arithmetic errors; failure to discount comp prep time [and travel time]; hours claimed after decision issued; ... administrative time not compensable; unproductive effort."

6.3. REASONABLENESS OF TIME BILLED

We must assess whether the hours claimed for the consumers' efforts that resulted in Substantial Contributions to the proceedings are reasonable by determining to what degree the hours and costs (if any costs are claimed) are related to the work performed and are necessary for the Substantial Contribution.[25]

a. Billed Activities. APPLICANT billed for approximately 13 activities summarized as follows:

(1) Preparation and editing of draft comments in January 2006, on the proposed

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[19] D.06-11-009 (November 9, 2006), p. 27.
[20] D.06-11-031 (November 30, 2006), p. 10.
[21] D.06-11-031 (November 30, 2006), p. 12; D.06-11-032 (November 30, 2006), pp. 14 – 15; D.06-11-009 (November 9, 2006), p. 32.
[22] D.06-11-031 (November 30, 2006), pp. 14 -15.
[23] D.06-11-032 (November 30, 2006), pp. 9 - 10.
[24] D.06-11-009 (November 9, 2006), Appendix p. 1.
[25] See, e.g., PUC D.06-11-031 (November 30, 2006), p. 10; D.06-11-032 (November 30, 2006), p. 9; D.06-11-009 (November 9, 2006), p. 26.

regulation for the next submission, for a total of 4.7 hours.

(2) Review documents, preparation for, attendance at, and participation in stakeholder meetings regarding the proposed regulation language, held in October and November 2006, for a total of 12.1 hours.

(3) Preparation for, attendance at, and present testimony at a Public Hearing held on March 5, 2007, regarding the proposed regulation, for a total of 5.2 hours.

(4) Analysis of the proposed regulation and preparation of written comments submitted by letter dated March 5, 2007, for a total of 7.4 hours.

(5) Preparation for, attendance at, and present testimony at a Public Hearing held on September 18, 2007, regarding the proposed regulation, for a total of 7.3 hours.

(6) Analysis of revisions to the proposed regulation and preparation of written comments submitted by letter dated September 21, 2007, for a total of 7.7 hours.

(7) Analysis of major revisions to the proposed regulation and preparation of written comments submitted by letter dated December 21, 2007, for a total of 5.3 hours.

(8) Attend and participate in meetings and conference calls with Department leadership and consumers in light of the OAL rejection of the proposed regulation, and preparation of comments for submission to the Department, for a total of 6.5 hours.

(9) Attend and participate in Department workshop meetings in June through October 2008, used to assist in drafting new proposed regulation language and address issues, including preparation of comments, review of other stakeholders' comments, and prepare further written comments; attend and participate in Department sponsored stakeholder workshops in September and October 2008, regarding specific timely access issues numbered 1 – 7, for a total of 43.8 hours.

(10) Research and draft comments for letter dated November 21, 2008, for a total of 7.0 hours.

(11) Research and draft comments for letter dated February 23, 2009, for a total of 4.0 hours.

(12) Participate in conference calls with Department leadership and prepare comments in a letter dated June 25, 2009, for a total of 6.3 hours.

(13) Research and draft written comments in a letter dated October 13, 2009, on the revised language of the regulation, for a total of 3.0 hours.

b. Adjustments. The time billed and costs billed appear(s) reasonable except for the following:

(1) Time billed at rates in excess of Market Rate. Time billed for APPLICANT's

Staff Attorney/Legislative Advocate and Staff Attorney for services exceeded Market Rate and is adjusted to be within Market Rate, as described in Paragraph 6.9, *infra.*

c. Finding. The Hearing Officer hereby finds that, as adjusted, the time billed is related to the work performed, necessary for the substantial contributions made, and reasonable for the advocacy and witness services performed and work product produced.

6.4. MARKET RATE

Public interest attorneys are entitled to request the prevailing market rates of private attorneys of comparable skill, qualifications and experience. (*Serrano v. Unruh* ("*Serrano IV*") (1982) 32 Cal.3d 621.). APPLICANT is entitled to be compensated for Advocacy Fees and Witness Fees at hourly rates that reflect Market Rate for services. Advocacy Fees and Witness Fees cannot exceed Market Rate, as defined in the Regulation. 28 CCR §§ 1010(b)(1), (3) and (10). "Market Rate" is defined at 28 CCR section 1010(b)(3) as follows:

> "'Market Rate' means, with respect to advocacy and witness fees, the prevailing rate for comparable services in the private sector in the Los Angeles and San Francisco Bay Areas at the time of the Director's decision awarding compensation for attorney advocates, non-attorney advocates, or experts with similar experience, skill and ability."

6.5. HOURLY RATES THAT REFLECT "MARKET RATE"

The Hearing Officer finds that hourly rates for services provided in a statewide proceeding or proceeding of a state agency having statewide jurisdiction and effect (such as proceedings of the PUC, see *infra*) are essentially equivalent to hourly rates for "comparable services in the private sector in the Los Angeles and San Francisco Bay Areas," as required by 28 CCR § 1010, subsection (b)(3). Accordingly, we must take into consideration whether the claimed fees and costs (if any) are comparable to the market rates paid to experts and advocates having comparable training and experience and offering similar services.[26] In order to determine Market Rate, we must look to available data inside and outside the Department.

6.6. APPLICANT'S JUSTIFICATION FOR RATES BILLED

In support of the hourly fee rates requested ($415.00 per hour for Staff Attorney/Legislative Advocate and $325.00 per hour for a Staff Attorney), APPLICANT submitted the following:

a. The requested rates are "reasonable" and "are well within the range of rates charged by private attorneys in Los Angeles and the Bay Area."

b. The rates sought by APPLICANT "are based on Insurance Commissioner awards." The rates should be based on decisions by the Insurance Commissioner because the Insurance

[26] See, e.g., PUC D.06-11-031 (November 30, 2006), p. 10; D.06-11-032 (November 30, 2006), p. 10.

Commissioner provides a better model than the PUC and because the Insurance Commissioner's regulations have language similar to the Department's regulations regarding market rate for fees. To support this basis, APPLICANT submitted a copy of one Insurance Commissioner rate decision awarding attorneys' fees to an applicant other than APPLICANT.

c. The award should be based on current rather than historical fee rates, to adjust historical rates for delay in payment.

d. Evidence supports the reasonableness of the rates sought by APPLICANT, including a declaration from an "expert on attorneys' fees" and legal fee survey data. Such evidence shows that prevailing hourly rates in Los Angeles and the Bay Area are higher than those sought here and much higher than the PUC rates.

6.7. APPLICANT'S ARGUMENTS FOR CHANGING RELIANCE FROM THE PUC HOURLY RATE RANGE DETERMINATIONS ARE UNPERSUASIVE

APPLICANT's claimed hourly attorneys' fee rates do not reflect Market Rate, and APPLICANT's arguments for changing the Department's reliance from the PUC hourly rates to APPLICANT's proposed rates are unpersuasive for, *inter alia*, the following reasons: (a) services in administrative rulemaking proceedings are distinguishable from litigation services; (b) APPLICANT's Application lacks justification for fee rates for administrative rulemaking proceedings; (c) use of surveys to determine prevailing rates for comparable services in the private sector in the Los Angeles and San Francisco Bay areas is problematic and unreliable; (d) rates used in Insurance Commissioner rate review decisions do not reflect Market Rate for determination of awards under the CPP; (e) award for services in prior years at hourly rates determined for services in the year of the award does not reflect Market Rate; and (f) prior awards received by APPLICANT in litigation forums reflect discount from fees requested and the awards actually received, and approximate PUC rates. Further analysis of these reasons is as follows.

a. Services in Administrative Rulemaking Proceedings Are Distinguishable from Litigation Services.

Advocacy and witness services in rulemaking proceedings are regularly provided by attorneys and non-attorney experts. Administrative rulemaking proceedings are not as complex as full blown litigation which requires more legal research, discovery, pretrial motions, trial and appellate work. The difference in complexity as well as the administrative rulemaking services being provided by non-attorneys render determination of Market Rate for fees for administrative rulemaking distinguishable from market rate for fees for litigation.

Prior awards received and used herein as justification by APPLICANT were primarily for litigation in state and federal courts and not administrative rulemaking proceedings. In the definition of Market Rate, "comparable services" should reflect the nature of this administrative proceeding versus the increased services and different skills necessary for full blown litigation in state and federal trial and appellate courts. The regulation itself reflects this view. "Comparable services" in this context, refers to "advocacy and witness fees," not the "non-contingent market rates charged by litigation attorneys" (in state and federal trial and appellate court litigation).

The Hearing Officer finds that the legal fee rates based on rates charged by litigation attorneys submitted by APPLICANT do not accurately reflect Market Rate for administrative rulemaking proceedings.

b. APPLICANT's Application Lacks Justification for Fee Rates for Administrative Rulemaking Proceedings.

In the Application, APPLICANT argues that the requested fee rates represent Market Rate based on the opinion presented in a Declaration of Richard M. Pearl ("Pearl") of the law firm Law Offices of Richard M. Pearl. Mr. Pearl specializes "in issues related to court-awarded attorneys' fees...,"[27] primarily involving decisions determining the reasonableness[28] of attorneys' fees requested. Pearl presented several examples of hourly rates found reasonable for litigation attorneys in litigation cases, as well as attorneys' fees rate information from surveys of litigation rates. Based on those litigation fee rates, Pearl opined that the rates sought by APPLICANT "... are well in line with the non-contingent market rates charged by litigation attorneys of similar qualifications and experience in the major California legal markets." (Emphasis added). Pearl Declaration, ¶ 8, p. 5.

However, the Pearl Declaration contains no information comparing attorneys' fees rates for administrative rulemaking to rates for litigation, nor does the Pearl Declaration contain justification for the fee rates for administrative rulemaking to be the same as fee rates for litigation.

By contrast, the PUC rates and rate ranges in administrative, rulemaking and ratemaking proceedings are supported by extensive information, evidence, testimony, and PUC hearings for several years, focused solely on rates and rate range determinations. See, ¶¶ 6.2 and 6.5, *supra*, and ¶ 6.8, *infra*.

The Hearing Officer finds that the APPLICANT's Application lacks justification for claimed fee rates for administrative rulemaking proceedings.

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[27] Declaration of Richard M. Pearl in Support of Western Center on Law and Poverty's Application to the Department of Managed Health Care for Advocacy Fees, dated March 15, 2010 ("Pearl Declaration").

c. Determination of Prevailing Rates for Comparable Services in the Private Sector in the Los Angeles and San Francisco Bay Areas Is Problematic if not Unreliable.

Conspicuously absent from the Pearl Declaration is a discussion of the "real world" characteristics of attorneys' fees charged by law firms and the effect of economic factors on hourly rates charged (collectively, "hourly rates characteristics"). For example:

(1) Hourly rates reported to surveyors in attorneys' fee rates surveys rarely reflect the actual rates charged because, for example:

(a) The rates reported are the rates the law firm wants to be recognized as charging but may not reflect rates ultimately charged to clients. All surveys typically have "margin of error" reported. No such margin of error is reported in these surveys.

(b) The actual rates charged vary with the client. The larger the client, the more of a discount is given in order to keep the client (i.e., the rates charged are lower than the rates reported to surveyors).

(c) The effective rates charged (especially for associate attorneys lacking practice experience) are less because the total amounts per legal work may be written down to reflect fair value to the client and to avoid being characterized as having the client pay for education of associate attorneys. With the write downs, the effective rates are lower than the rates reported to surveyors.

(2) Fee awards in litigation cases are the product of motions for fees which impact the final rates awarded, and such rates are typically reduced from the rates requested. Indeed, the Declaration of Richard A. Rothschild, Director of Litigation for APPLICANT, concedes that APPLICANT's requests for attorney fees resulted in stipulated orders based on agreements by APPLICANT to accept at most 85-95% of amounts APPLICANT originally sought. Moreover, these stipulated orders did not specify hourly rates.[29]

The Hearing Officer finds that legal fee surveys of rates charged by litigation attorneys as submitted by APPLICANT do not accurately reflect Market Rate for administrative rulemaking proceedings nor for the Timely Access proceeding.

d. Rates Used in Insurance Commissioner Rate Review Decisions Do Not Reflect Market Rate for Determination of Awards Under the Consumer Participation Program.

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[28] Determinations of whether attorneys' fees are "reasonable" may, and usually do, differ from determinations of whether fees represent market rate. A fee rate may exceed market rate but may be determined to be "reasonable" under the circumstances and be awarded.

[29] Declaration of Richard A. Rothschild In Support Of Application For Advocacy Fees, dated March 16, 2010, ¶ 8 at p. 3 ("Rothschild Declaration").

In its Application, APPLICANT argues that the Department should reconsider its reliance on hourly rates awarded in PUC decisions because the Insurance Commissioner ("Commissioner") provides a better model than the PUC. APPLICANT attached and relied on one Insurance Commissioner Decision[30] ("DOI Decision"). No other decisions of the Insurance Commissioner were attached, cited or referenced by APPLICANT.

In the DOI Decision, the requested hourly rates were supported by: (1) a declaration by one of the attorneys for whom compensation was being requested, attesting to the reasonableness of the attorneys' hourly rates; and (2) a declaration submitted in a different matter written by Richard M. Pearl, an expert on attorneys' fees, which opined that the requested rates were "consistent with the market rates for San Francisco and Los Angeles legal markets for attorneys with similar experience."[31] ("Pearl Declaration"). It appears that the Commissioner granted the rates requested solely on the basis of one individual's declaration (the Pearl Declaration). The Commissioner did not consider the PUC hourly rates, rate ranges, or any other evidence, model or justification. No other opinion was sought, received, or utilized by the Insurance Commissioner in granting the hourly rates of the fee award.[32] Using only one opinion (filed in another proceeding) runs the risk of one expert being the determiner of market rates by merely testifying that, in his/her opinion, the requested rates are consistent with the market rates for San Francisco and Los Angeles legal markets for attorneys with similar experience.

Based on the presentation of the DOI Decision, it appears that the DOI attorneys' fees rate determinations are on a case-by-case basis and rely on the "expert testimony" of only one declarant. The case-by-case analysis was the process used by the PUC until 2004,[33] when the PUC commenced a distinct proceeding to determine attorney fee rates and rate ranges, using extensive hearing evidence and testimony.

The Hearing Officer finds that the Insurance Commissioner's case-by-case or piecemeal basis for determining hourly rates is less accurate and effective in determining Market Rate than the PUC

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[30] Insurance Commissioner File No. IP-2007-00006 (Decision Awarding Compensation to Foundation For Taxpayer and Consumer Rights In the Matter of the Rate Applications of Explorer Insurance Company (PA-2007-00013))

[31] *Id.* at p. 12.

[32] The DOI Decision awarded $504,295.27, in a single decision, and the insurance company licensee was ordered to pay the award. By contrast, the CPP Statute limits to $350.000 the total annual amount available to award advocacy and witness fees.

[33] Until PUC Decision R.04-10-010 in 2004, the PUC "set hourly rates piecemeal" for intervenors. PUC Order Instituting Rulemaking R.06-08-019 (August 24, 2006), p. 2.

methodology based on rulemaking proceedings and hearings to determine hourly rates fairly and equally for all intervenors (applicants) in rulemaking proceedings and hearings.

e. Award for Services in Prior Years at Hourly Rates Determined for Services in the Year of the Award Does Not Reflect Market Rate.

In the Application, APPLICANT argues that the award should be at "current rates" (hourly rates in effect on the date of the award decision), regardless of how many past years' services are covered by the award. Applicant's rationale is that use of current rates is appropriate to adjust for delay in payment and/or eliminates the need for a multiplier for delay in payment.

Compensation for delay in payment is not contemplated by the Statute and regulation applicable to the Program. Participant services regarding the Regulation could have begun in 2004. Yet, an application for an award of compensation could not have been submitted until January 17, 2010 (the effective date of the Regulation) (28 CCR § 1010(e)(1)). It should be noted in this context that the Timely Access Regulation was the result of three separate proceedings, and APPLICANT requests an award for services beginning in 2006. It appears inappropriate and inconsistent with Market Rate to award payment for 2006 services at 2010 rates.

The Hearing Officer finds that: (1) an award at current hourly rates for services in prior years is inconsistent with Market Rate; and (2) an award for services in prior years must be at rates applicable to those prior years in order to be consistent with Market Rate.

f. Prior Awards Received by APPLICANT Reflect Discount from Fees Requested and Approximate PUC Rates.

In APPLICANT's current and prior Applications, APPLICANT had not attached fee award orders from other forums showing hourly rates. The absence of hourly rates reflected in prior fee awards to APPLICANT is because those prior awards were the result of stipulations regarding the amount of the award without mentioning hourly rates. Therefore, we have no evidence of hourly rates awarded to APPLICANT in litigation matters, and we have no comparable hourly rates to use for comparison, even though such comparison would have to take into account the differences between fees for litigation and fees for administrative/regulatory proceedings. "For the past several years, every fee award Western Center has recovered in Los Angeles and the Bay Area has been through stipulated orders. ... In each case, we reached agreement – usually totaling 85 – 95% of what I initially asked for – that did not specify hourly rates awarded."[34] It can be inferred that reaching a fee agreement "through stipulated orders" means the fees were reduced from the fees requested. APPLICANT currently requests fees at rates of $415/hour and $325/hour. By reducing

the highest fee rate requested by a percentage mentioned in the Rothschild Declaration, the PUC rates are approximated. For example: 85% of APPLICANT'S requested rate of $415/hour equals $352.75/hour, which is lower than the PUC rate for work in 2008 and 2009 ($355/hour) and very near the rates for 2006 ($335/hour) and 2007 ($345/hour). It cannot be ignored that rates awarded to APPLICANT in other forums have been arrived at (i.e., reduced from rates requested) by stipulation, whether by reducing hourly rates or otherwise. Equally important is that those awards in other forums were for full blown litigation in state or federal court.[35]

The Hearing Officer finds that the fee awards to APPLICANT in other forums do not support the fee rates requested by APPLICANT herein as meeting the requirement of Market Rate.

6.8. HOURLY RATE DETERMINATIONS UNDER THE PUC PROGRAM

Until PUC Decision R.04-10-010 in 2004, the PUC "set hourly rates piecemeal"[36] for intervenors – i.e., "... for each proceeding, each intervenor, and indeed each appearance by a particular representative of an intervenor, ... [the PUC] might revisit the reasonableness of that representative's hourly rate."[37] The PUC recognized the need for coordination by establishing, through periodic rulemakings, the rates to be paid to all intervenors' representatives for work done in specified time periods.[38] The first such rulemaking was R.04-10-010, D.05-11-031, which set certain guidelines, recognized that hourly rates had stabilized, and determined that the PUC would not authorize a general increase to intervenor hourly rates for work performed in 2005.[39]

In an Interim Opinion on Updating Hourly Rates,[40] the PUC adopted a three percent (3%) cost-of-living adjustment ("COLA") for work performed in calendar year 2006, adopted an additional 3% COLA for work performed in 2007, and established, effective for 2007 work, three rate ranges for non-attorney experts based on levels of experience, similar to the five levels already established for attorneys.[41] The three levels for non-attorney experts are: 0-6 years; 7-12 years; and 13-plus years. In so doing, the PUC found that:

> "...basing expert rates on levels of experience, similar to the levels established for attorneys, will better ensure that an expert's given rate is within the market rates paid to persons of comparable training and experience. However, in no event should the rate requested by an intervenor exceed the rate billed to that intervenor by any outside

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[34] Rothschild Declaration, ¶ 8 at p. 3.
[35] *Id.* at pp. 1-2.
[36] PUC Order Instituting Rulemaking R.06-08-019 (August 24, 2006), p. 2.
[37] *Id.*
[38] *Id.*
[39] *Id.* at pp. 2-3.
[40] D.07-01-009 (January 11, 2007) (part of Rulemaking R.06-08-019).
[41] *Id.* at pp. 1, 3-4.

consultant it hires, even if the consultant's billed rate is below the floor for a given experience level. ...[I]ntervenors must disclose the credentials of their representatives in order to justify the requested rates.[42] (Emphasis added).

The following table shows the PUC's adopted ranges for work performed by intervenor representatives in 2006, 2007, 2008 and 2009. The rate ranges for attorneys and non-attorney experts are based on levels of applicable experience.

Hourly Intervenor Rate Ranges for 2006, 2007, 2008[43] and 2009

(2006 rates = rates adopted in D.05-11-031 + 3%, rounded to nearest $5)
(2007 rates = rates adopted for 2006 in D.07-01-009 + 3%, rounded to nearest $5)
(2008 rates = rates adopted for 2007 + 3%, rounded to nearest $5)
(2009 rates = 2008 rates adopted for 2009 in Resolution ALJ-235)

Years of Experience	2006 Range	2007 Range	2008 and 2009[44] Range
Attorneys:			
0 - 2	$140 - $195	$145 - $200	$150 - $205
3 - 4	$190 - $225	$195 - $230	$200 - $235
5 - 7	$260 - $280	$270 - $290	$280 - $300
8 - 12	$280 - $335	$290 - $345	$300 - $355
13+	$280 - $505	$290 - $520	$300 - $535
Experts:			
0 - 6		$120 - $180	$125 - $185
7 - 12		$150 - $260	$155 - $270
13+		$150 - $380	$155 - $390
All years	$115 - $370		

Note: The rates intervenors request for the use of outside consultants may not exceed the rates billed to the intervenors by the consultants, even if the consultants' rates are below the floor for any given experience level.

The PUC decided to continue to update hourly rates annually on a calendar year basis.[45] The PUC based its 3% COLA adjustments on the Social Security Administration's COLA, which is

[42] *Id.* at p. 5.
[43] D.08-04-010 (April 10, 2008) (part of Rulemaking 06-08-019) at p. 5.
[44] For work performed in 2009, the PUC ordered that intervenors are not authorized an hourly rate COLA, and hourly rate ranges adopted for 2008 remain in effect. Resolution ALJ-235 (March 12, 2009) at pp. 2-4.
[45] D.07-01-009 (January 11, 2007) at p. 9.

released annually in late fall, and upon which reliance would be consistent with a calendar year adjustment of hourly rates.[46]

In 2008, the PUC found it reasonable to adopt another 3% COLA for intervenor rates for work performed in 2008.[47] That increase is primarily based on various federal inflation indexes, such as the Social Security Administration's COLA and Bureau of Labor Statistics data for consumer prices and wages.[48] In its 2008 Decision and for future reference, the PUC found that a COLA adjustment should be authorized, by future PUC Resolution, for work performed in 2009, and in subsequent years in the absence of a market rate study, to be effective on January 1 of each year.[49] However, a COLA would not necessarily be authorized. By Resolution ALJ-235 (March 12, 2009), the PUC ordered that intervenors are not authorized an hourly rate COLA for work performed in 2009, and hourly rate ranges adopted for 2008 would remain in effect.

6.9. DETERMINATION OF MARKET VALUE HOURLY RATE

Fees claimed may be adjusted to reflect Market Rate. "The hearing officer shall issue a written decision that ... shall determine the amount of compensation to be paid, which may be all or part of the amount claimed." 28 CCR § 1010(e)(7). APPLICANT claims advocacy and witness fees for one Staff Attorney/Legislative Advocate and one Staff Attorney.

For work performed by APPLICANT's Staff Attorney/Legislative Advocate, APPLICANT claims Advocacy and Witness Fees at the hourly rate of $415.00 for 2006, 2007, 2008 and 2009. The PUC's adopted hourly intervenor rate ranges for attorneys with 8 – 12 years of experience are as follows: for 2006, $280 - $335; for 2007, $290 - $345; for 2008 and 2009, $300 - $355 (see ¶ 6.8, *supra*). At the time of the work for which claim is made (2006, 2007, 2008 and 2009), APPLICANT's Staff Attorney/Legislative Advocate had approximately 8 - 11 years of experience. APPLICANT submitted justification for the rate claimed by reference to: the number of years of experience for each staff member for whom fees are claimed; one Insurance Commissioner rate hearing decision; survey data indicating litigation rates allegedly paid to private law firms; a declaration of an expert in attorneys' fees; and other information (see ¶ 6.6, *supra*). The highest of the PUC's rates for attorneys with 8 - 12 years of experience is $335.00 for 2006, $345.00 for 2007, and $355.00 for 2008 and 2009. Therefore, it appears that the $415.00 hourly rate claimed for 2006, 2007, 2008 and 2009 by APPLICANT exceeds Market Rate as discussed and found herein. The

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[46] *Id.* at pp. 4 and 11.
[47] D.08-04-010 (April 10, 2008) at pp. 4 and 24.
[48] *Id.* In reviewing available data, the PUC found no index that specifically targets rates for services by regulatory professionals (attorneys, engineers, economists, scientists, etc.), and the PUC's "findings are weighted heavily to SSA COLA and similar data." *Id.* at p. 4.

Hearing Officer finds that the hourly rate requested by APPLICANT exceeds Market Rate and therefore will be adjusted. Regarding services provided by APPLICANT's Staff Attorney/Legislative Advocate, the Hearing Officer finds that $335.00 per hour is consistent with Market Rate for the services provided in 2006, $345.00 per hour is consistent with Market Rate for the services provided in 2007, and $355.00 per hour is consistent with Market Rate for the services provided in 2008 and 2009.

For work performed by APPLICANT's Staff Attorney, APPLICANT claims Advocacy and Witness Fees at the hourly rate of $325.00 for 2008 and 2009. For 2008 and 2009, the PUC's adopted hourly intervenor rate range for attorneys with 3 – 4 years of experience are as follows: $200 - $235 (see ¶ 6.8, *supra*). The Application attempts to establish that APPLICANT's Staff Attorney had five years of experience at the time of the work for which claim is made, by reference to APPLICANT's Staff Attorney as having five years of experience or as a "five-year attorney." Respectfully, that is not factually accurate. APPLICANT's Staff Attorney was admitted to the California State Bar on December 5, 2005. The last time entry for which claim is made is dated October 13, 2009, not quite four years after being admitted to the Bar. Accordingly, the Hearing Officer finds that at the time of the work for which claim is made (February 7, 2008 through October 13, 2009), APPLICANT's Staff Attorney had approximately 3 – 4 years of experience for 2008 and 2009, after being admitted to the California State Bar in December, 2005. APPLICANT submitted justification for the rate claimed by reference to: the number of years of experience for each staff member for whom fees are claimed; Insurance Commissioner rate hearing decisions; survey data indicating rates allegedly paid to private law firms; a declaration of an expert in attorneys' fees; and other information (see ¶ 6.6, *supra*). The highest of the PUC's rates for attorneys with 3 - 4 years of experience is $235.00 for 2008 and 2009. Therefore, it appears that the $325.00 hourly rate claimed for 2008 and 2009 by APPLICANT exceeds Market Rate as discussed and found herein. The Hearing Officer finds that the hourly rate requested by APPLICANT exceeds Market Rate and therefore will be adjusted. Regarding services provided by APPLICANT's Staff Attorney, the Hearing Officer finds that $235.00 per hour is consistent with Market Rate for the services provided in 2008, and $235.00 per hour is consistent with Market Rate for the services provided in 2009.

Based on the information and documentation provided by APPLICANT, the Hearing Officer did not consider it necessary to audit the records and books of the APPLICANT to verify the basis for the amounts claimed in seeking the award. 28 CCR § 1010(e)(6).

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[49] D.08-04-010 (April 10, 2008) at pp. 24 -25.

7. AWARD

APPLICANT is awarded Advocacy and Witness Fees as follows:

Staff / Title	Hours	Rates	Fees
Staff Attorney/Legislative Advocate			
-- Work in 2006	12.1	$335.00	$4,053.50
-- Work in 2007	32.9	$345.00	$11,350.50
-- Work in 2008	42.6	$355.00	$15,123.00
-- Work in 2009	4.6	$355.00	$1,633.00
Staff Attorney -- Work in 2008	19.7	$235.00	$4,629.50
-- Work in 2009	9.6	$235.00	$2,256.00
TOTAL FEES	→		**$39,045.50**

8. ASSIGNMENT OF PROCEEDING

This proceeding was and is assigned to Stephen A. Hansen, Staff Counsel III, as Hearing Officer.

FINDINGS OF FACT

1. APPLICANT has satisfied all the procedural requirements necessary to claim compensation in this proceeding.

2. APPLICANT made Substantial Contributions to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 as described herein.

3. APPLICANT requested hourly rates for its representatives that, as adjusted herein, are reasonable when compared to Market Rates for persons with similar training and experience.

4. The total reasonable compensation for APPLICANT is $39,045.50.

CONCLUSIONS OF LAW

1. APPLICANT has fulfilled the requirements of Health and Safety Code § 1348.9 and 28 CCR § 1010, which govern awards of advocacy and witness compensation, and is entitled to such compensation, as adjusted herein, incurred in making Substantial Contributions to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 and 28 CCR § 1300.67.2.2.

2. APPLICANT should be awarded $39,045.50 for its contribution to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 and 28 CCR § 1300.67.2.2.

AWARD ORDER

1. The Western Center On Law And Poverty, Inc., a California corporation, is hereby awarded $39,045.50 as compensation for its Substantial Contribution to the Timely Access regulatory Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 and to 28 CCR § 1300.67.2.2.

2. Payment shall be made within thirty (30) days of the effective date of this decision.

3. This decision is effective thirty (30) days after posting of this decision on the Department's website. 28 CCR § 1010(e)(7) and (8).

Dated: June 29, 2010

Original Signed by:

STEPHEN A. HANSEN
Hearing Officer
Department of Managed Health Care